Appendix 1: Complete List of Reopening Statements

This appendix represents a list of all final consensus and non-consensus statements after round 1 and round 2 of voting. Those statements that did not reach consensus, <80% are highlighted in yellow.

Definitions:

- Modification of the formal CDC definition of Healthcare personnel (HCP). "HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, feeding assistants, students and trainees, contractual HCP not employed by the healthcare facility, and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, beauticians and hairdressers, engineering and facilities management, administrative, billing, and volunteer personnel)". (Added Beauticians to CDC definition of HCP)
- Testing, Active/Surveillance: Testing for active surveillance of asymptomatic individuals.
- Testing, Outbreak Investigation: Testing of symptomatic or asymptomatic residents in response to an outbreak investigation of a positive staff or resident case.
- Testing, Diagnostic: Testing of symptomatic residents or staff.
- NH-onset COVID-19 infection: a COVID-19 unknown or negative nursing home resident who tests positive for COVID-19 more than 14 days after admission to the facility.
    - A NH-onset COVID-19 infection definition does not include an asymptomatic COVID-19 resident who has recovered from the disease but tests positive within 90 days of onset of symptoms. – 68% agreement

Criteria for Entrance into Phase 3

- Staff
    - The nursing home has designated one or several staff members who are engaged in infection prevention and oversight of local facility COVID-19 response and procedures.
    - The facility and local health district should have a proposed plan to mitigate and assist in any staffing shortage as deemed necessary for routine patient care, including assisting residents with ADL care and companionship.
    - There should be a respiratory protection plan in place for the nursing home to include staff fit testing for N95 masks.
- Isolation and Cohorting
    - There is a written isolation and cohorting plan submitted to the local health department.
- Admissions

    - There is a written process for new admissions that includes appropriate isolation and precautions for all new residents submitted to the local health department.
- Testing
    - Completion of Phase 1 and 2 requirements to include at least one round of universal testing of all healthcare staff and residents who have not previously tested positive.
    - There is a written screening and testing plan submitted to the local health department.
- Supplies
    - There should be at least a 14-day supply of adequate PPE supplies for the nursing home to be able to manage daily patient flow and planning for a potential surge of COVID-19 positive patients.
    - There should be sufficient disinfecting supplies including hand sanitizer, soap, detergent, etc for 14-days in stock.
- Overall local community health metrics should be improving as evidenced by a community test positivity rate <10% and adequate local hospital capacity defined by the local health department.
- Regular reporting to the CDC NHSH LTCF COVID-19 module is occurring weekly (staffing, PPE, testing).
- In order for a nursing facility to proceed with phased reopening, there should be no new NH-onset cases for 28 days. 74% agreement

Universal Source Control

- Direct patient care staff wear the appropriate PPE when interacting with residents.
- Social distancing, hand washing, and disinfection practices need to continue in direct-patient care areas.
- Residents, visitors, and volunteers wear cloth face coverings or a facemask when in a shared-space.

Screening

- All persons entering the facility (including staff, visitors, volunteers, and vendors) should undergo screening to include: temperature check, exposure questionnaire, and symptom questionnaire.
- Entry screening is performed by a screener who has received training in basic infection control, appropriate education on questionnaires and hands-on practice with thermometer.
- All persons attempting to enter the facility who have either recorded a temperature >99.5 F or report having taken a medication to treat fever (anti-pyretic such as acetaminophen) should not be permitted to enter.
- All residents should undergo a daily symptom screening and have temperature monitored.

Testing and Surveillance

- Symptomatic Residents/Staff
    - Test all symptomatic residents and staff but allow individual residents autonomy with an appropriate plan on how to isolate and cohort a resident who is symptomatic but does not wish to be tested.
    - A symptomatic staff member who does not wish to be tested would be excluded from work until they meet the return to work criteria of a presumed positive individual.
    - Treat a symptomatic resident who does not wish to be tested as a presumed positive. Isolate and cohort accordingly.
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- Asymptomatic Residents/Staff
    - All residents, staff should have undergone baseline testing as part of Phase 1 and Phase 2.
    - Have a plan for ongoing surveillance testing of asymptomatic staff and residents.
        - Testing a proportion of randomly selected asymptomatic HCP (staff) who have not previously tested positive should be done for surveillance efforts. The frequency and sample size of staff should be guided by size of facility and level of local community spread. – 79% agreement
        - In facilities without any positive COVID-19 cases, test 100% of asymptomatic HCP (staff) who have previously not tested positive weekly for 4 weeks; if no new positives may test 25% of asymptomatic HCP (staff) every 7 days such that 100% of facility staff are tested each month. 53% agreement
        - Testing a proportion of randomly selected asymptomatic resident who have not previously tested positive should not be done for surveillance efforts. Instead, residents who are asymptomatic should only be tested during outbreak investigations of close contacts of a known COVID-19 positive resident or staff member. 53% agreement
        - Residents who are asymptomatic should be allowed to opt out of testing for sole purposes of surveillance. This statement would not be applicable for contact tracing with a known exposure to a COVID-19 patient or staff member. – 68% agreement
    - Triggers to increase testing:
        - A trigger to increase testing of asymptomatic individuals would be based on response to an outbreak investigation and contact tracing results.
        - One COVID-19 + case in staff or residents should trigger the execution of a comprehensive plan addressing contact tracing, isolation/cohorting, and testing within 24 hours of positive test result.

        - During an outbreak investigation, there should be a low threshold to extend testing of all staff and residents to entire units, floors, buildings if the situation deems it necessary.
        - Asymptomatic residents and staff who have previously tested positive would not be subject to repeat testing.
        - Once one NH-onset case (case definition from CDC) has been identified within a facility, facilities should resume testing of asymptomatic HCP (staff) who have not previously tested positive
    - The facility should make every effort possible to secure a collection method that is least invasive and uncomfortable if testing residents and staff with a low pre-test probability of COVID-19 disease (asymptomatic without known exposure), such as saliva testing or nasal/oral swabs instead of a nasopharyngeal swab.
    - Asymptomatic COVID-19 recovered resident
        - An asymptomatic resident who has previously tested positive for COVID-19 and recovered does not need to be tested again within an 8 week window of prior onset of symptoms. 74% agreement
        - An asymptomatic resident who has previously tested positive for COVID-19 and recovered does not need to be tested again within a 90 day window of prior onset of symptoms. 58% agreement
        - An asymptomatic resident who has previously tested positive for COVID-19 and recovered does not need to be tested again. 11% agreement

Contact Tracing

- A process should be identified for how facilities will actively track staff/ resident and visitor interactions to help facilitate appropriate contact tracing in the event of an outbreak investigation.
- In the event of a PUI or COVID-19 positive staff or resident, a list of individuals with possible exposures should be able to be generated for the prior 3 days (preferably 5 days) within 24 hours.

Cohorting and Isolation

- Facilities should be aware and document individual resident and/or surrogate decision-makers' care preferences regarding testing, cohorting, and isolation. It may be possible to cohort a certain group of individuals (ie recovered COVID-19 positive patients who are asymptomatic) as long as the risks for other residents is not substantially increased.
- New admissions should be placed in a dedicated area of the facility where appropriate isolation and contact precautions are maintained.
- There should be a written cohorting and isolation plan for the facility.
- A facility should have a designated area for cohorting of COVID-19 positive residents even if no active cases exist.

- Facilities should be able to accommodate individual resident care preferences regarding testing, cohorting, and isolation as long as the individual risks for other residents is not substantially increased. 75% agreement

Visitor Guidelines

- Screening
    - Screening of all visitors and volunteers should be performed.
    - Visitors that do not adhere to recommendations or do not allow screening procedures to take place such as temperature checks would not be allowed in the building.
    - A negative COVID-19 test is not a requirement prior to visiting a nursing home. 70% agreement
- Visit Logistics
    - During visits with family or friends, a facility may need to limit the number of visitors to no more than 2 visitors during one visit due to physical space constraints in order to allow social distancing to take place.
    - The facility should maintain a sign-in log that includes contact information (phone and email) of visitors and volunteer to help with contact tracing.
    - A process should exist by which visitors and volunteers can sign up for a defined time period, preferably electronically.
- Infection Prevention Strategies
    - Social distancing, hand hygiene and mandatory face masks are required in shared-spaces during visits.
    - Visitors should be guided to the visitor area as to limit their interactions with other areas, staff or patients.
    - Gloves and a gown are required if visitors wish to engage in physical contact with a nursing home resident, such as hugging, hand holding, or meal assistance.
- Location
    - Nursing homes should have a designated area for visitations to occur. Ideally outside, except for situations where the outdoor conditions would not allow a safe visit.
    - Indoor visitation areas should be accessible without walking through a patient care area, must be disinfected between scheduled visits, and should be large enough to facilitate social distancing between different visitor groups.
- Dedicated support person
    - Visitor guidelines should prioritize and make special arrangements to allow a designated care giver (or dedicated support person) or surrogate decision-maker the ability to frequently visit and provide compassionate care to a resident exhibiting behaviors that require frequent re-direction in cases of delirium, dementia, or other psychosocial distress.
- Symptomatic Residents

    - Visitors who wish to visit a nursing home resident who is actively symptomatic and has tested positive for COVID-19 should be strongly discouraged from visiting with the exception of compassionate visitations at the end-of-life. All appropriate level II PPE must be worn at that time.
    - Visitors who wish to visit a nursing home resident who is actively symptomatic but for whom COVID-19 testing is pending or unknown should have an informed consent discussion with nursing leadership, demonstrate appropriate donning/doffing of PPE and agree to wear appropriate PPE during the visit. 47% agreement

Healthcare Personnel

- The facility should consider a designated care giver (or dedicated support person, surrogate decision-maker) an essential member of the healthcare team who would not be subject to visitor guidelines if resources (PPE, training, monitoring) are available at the time and the person is directly engaged in compassionate care to alleviate a residents psycho-social stress as a result of isolation. 79% agreement
- Allow entry of all essential and non-essential healthcare personnel, contractors, and vendors with appropriate screening, social distancing, hand hygiene, and face coverings. They would be subject to the same testing and surveillance requirements as the rest of the HCP (staff) cohort. Visitors including non-employed caregivers and surrogate-decision makers would be subject to the visitor guidelines. 74% agreement

Communal Dining

- Do not allow symptomatic residents with an unknown COVID-19 status entry into a shared communal dining environment.
- Cohort dining groups according to level of exposure and risk. For example, if necessary to accommodate resident/surrogate preferences, a risk-accepting group could be a cohort that attends congregate events together, provided that the facility can manage them separately.

Group Activities

- Do not allow symptomatic residents with an unknown COVID-19 status to participate in group activities in which proper infection control practices cannot be maintained.
- Make every effort possible to maintain social distancing, practice hand hygiene, and wear a mask during group activities.
- Try to facilitate indoor group activities in a well-ventilated space that allows for appropriate social distancing.
- Make an effort to offer residents the ability to join a risk-accepting group that could be cohorted together for activities, provided that the facility can manage them separately.

Non-medically Necessary Trips Outside Facility

- Residents must adhere to face coverings, hand hygiene, and social distancing during trips outside of the facility.
- Isolation
    - A resident who engages in a supervised outside visit with family or friends within the nursing home grounds, remains outside, and the visit does not involve close contact with COVID+ individuals or symptomatic individuals would not be subject to isolation upon re-entry to the facility.
    - A resident that makes a trip outside the facility and is exposed to a COVID+ individual, symptomatic individual or otherwise fails the screening questionnaire upon re-entry to the building would be subject to 14 days of isolation.
    - A resident who engages in a visit with family or friends beyond the nursing home grounds, remains outside, and the visit does not involve close contact with COVID+ individuals or symptomatic individuals would not be subject to isolation upon re-entry to the facility. 17% agreement
- Infection Control
    - After a resident returns from an outside trip beyond the nursing facility grounds and prior to the resident resuming activities within a shared space, the resident should practice hand hygiene and have their wheelchair and belongings disinfected.
    - After a resident returns from an outside trip beyond the nursing facility grounds and prior to the resident resuming activities within a shared space, the resident should be bathed according to accepted practice with soap and have the clothes they were wearing laundered in a standard fashion. 47% agreement
- Leave of absence
    - The facility should have a discussion regarding risks/benefits with every resident and family who requests a leave of absence with a bed hold. This would include a discussion on hand hygiene, social distancing, and mask covering as well as subsequent isolation upon return to the facility if deemed necessary at the time of the visit based on level of community spread.

Outbreak Investigation and Phase Regression

- Phase regression and facility wide restrictions should not be imposed after one isolated COVID-19 case. Rather, a prompt outbreak investigation should occur with further results triggering appropriate restrictions.
- Response to positive resident
    - Once one nursing home resident tests positive for COVID-19, an outbreak investigation should include baseline testing of close contacts (to include roommate, neighboring rooms, and staff)

    - Once one NH-onset case (case definition from CDC) has been identified within a facility, facilities should resume testing of asymptomatic HCP (staff) who have not previously tested positive.
    - During an outbreak investigation of a single case it is determined that there is 1 NH-onset case on an isolated wing with isolated staff. This scenario would warrant testing of the entire wing staff and residents but not warrant facility wide testing or phase regression.
    - A new SNF admission who has remained under isolation in a private room becomes symptomatic within 14 days of admission and tests positive. In this situation, I would re-test and extend testing to close contacts. If no further positive cases, this situation would not warrant facility wide testing or phase regression.
    - A new or returning asymptomatic nursing home resident without a prior diagnosis of COVID-19 and who has remained under isolation in a private room for 14 days since admission tests positive during facility testing of asymptomatic residents. Not during an outbreak investigation and there has been no exposure to a COVID-19 positive patient or staff. In this situation, I would re-test the resident only. If subsequently negative and no further suspicion of COVID-19 in the building, this scenario would not warrant facility-wide testing or phase regression. 74% agreement
- Response to positive HCP
    - An asymptomatic HCP tests positive on routine surveillance testing and is appropriately following work-restrictions. This scenario should prompt an outbreak investigation of close contacts but should not automatically warrant a phase regression as long as the outbreak investigation does not identify new cases among staff or residents who have not previously tested positive.
    - A symptomatic HCP tests positive. This would warrant testing of close contacts (staff and residents) of the immediate patient care area.
    - Once one nursing home staff member tests positive for COVID-19, an outbreak investigation should include baseline testing of close contacts (to include roomate, neighboring rooms, and staff)
- Phase Regression
    - During an outbreak investigation, it is determined that there is >2 NHonset cases in a building within a short time period (<14 days). There is concern for wide spread disease in the building. This scenario would warrant testing of the entire facility and phase regression with subsequent restrictions on visitors, communal dining, and group activities.

Immunity

- A patient who has recovered from COVID-19 disease and is 3 weeks post onset of symptoms is likely not infectious to another individual as long as they have not developed new symptoms.
- A cohort of asymptomatic individuals who have all recovered from COVID-19 can safely be cohorted together.
- Antibody testing can be a surrogate marker of individual immunity but does not currently inform clinical practice; recovery from prior infection does. 69% agreement
- COVID-19 recovered individual
    - A currently asymptomatic individual who has recovered from COVID-19 and is post 8 weeks from onset of symptoms is not considered infectious and should not be tested. If tested and the test returns positive, as long as the resident remains asymptomatic, it would not be considered a re-infection and the patient is not contagious. 65% agreement
    - A currently asymptomatic individual who has recovered from COVID-19 and is post 90 days from onset of symptoms is not considered infectious and should not be tested. If tested and the test returns positive, as long as the resident remains asymptomatic, it would not be considered a re-infection and the patient is not contagious. 53% agreement
    - A currently asymptomatic individual who has recovered from COVID-19 is not considered infectious and should not be tested. If tested and the test returns positive, as long as the resident remains asymptomatic, it would not be considered a re-infection and the patient is not contagious. 35% agreement

Special Patient Populations, Scenarios

- Hairdressers, beauticians, hospice staff and other staff members who work within a nursing home should be included in the CDC definition of Healthcare Personnel (HCP) and follow the same guidelines regarding screening and testing.
- Hairdressers and stylists should be considered direct patient care staff and be subject to the same screening and work restrictions as other healthcare facility staff.
- Patients that are unable to adhere to social distancing or face coverings should be allowed to visit with family in a private isolated area as long as visitors were full PPE.
- Dialysis patients who leave the facility regularly for hemodialysis will remain under appropriate isolation and contact precautions and not mix with COVID-, asymptomatic individuals.